respect" made use of in the resolution of the General Medical Council. He concludes: "But I believe that neither Sir John Williams, Dr. Watt Black, nor I, who have acted first as Chairman of the Midwifery Board, and afterwards have been called to the presidential chair, and are therefore, perhaps, the most "infamous" among "infamous" men, feel the least ashamed of our work, conscious as we are of our own integrity, and of the great injustice which has been done to us all. As regards the form of our certificate, if the General Medical Council had told us that they thought it open to objections, we should have at once done what we are now doing—asked for its criticism with a view to their removal.

To have helped us to remove any cause of offence would have earned our gratitude.

I cannot but think that when it has mastered the subject, and had time to think, the General Medical Council will regret what it has done, not only towards men as honourable as any of its members—whose life and work are well known to it—but to a meritorious and public-spirited Society.

Meanwhile the agitators may rest assured that it has not seen the last of our examination, nor of us.

It is a significant fact that the number of candidates for our last examination has hardly ever been exceeded, not less than 114 women having presented themselves, and that in spite of our having held our certificate in abeyance.

If there is one thing certain in the world, it is the ultimate triumph of right. It may be opposed—it may be misunderstood—it may be reviled—it may have to suffer; but—

Magna est veritas, et prævalebit."

THE TREATMENT OF OZÆNA: A PRELIMINARY NOTE.

By G. HUNTER MACKENZIE, M.D.,

Surgeon for Diseases of the Throat and Nose to the Eye, Ear, and Throat Infirmary, Edinburgh.

ON May 28th, 1890, a young lady was sent to me by Mr. G. W. Watson, L.D.S., of Edinburgh, on account of a foetid discharge from the nose. This had lately been so intense as to induce complaints from the governesses and pupils of the school which she attended, and ultimately the girl was requested to discontinue attendance. She had been taken to Mr. Watson under the impression that her teeth might be at the bottom of her trouble; but as these were found quite sound, and Mr. Watson readily recognised that ozæna was present, she was sent to me.

The patient was one of the worst examples of ozæna that I have seen. Large putrid crusts blocked both nares, and, when removed, reformed by the following day. The nose was broadened, and the alæ were thickened and reddened. The patient was put under treatment during the summer and part of the autumn of the same year, and I saw her occasionally during 1891. Treatment was entirely discontinued after 1890.

On October 27th, 1894, about four years after the discontinuance of all treatment, I received a note regarding the case from Mr. Watson, of which the following is an extract: "I saw your old patient Miss C. recently, and thought it would interest you to know that she is quite cured of the ozæna. She says she is quite well again, and has no discharge; nor was there any odour perceptible when I examined her. She looks a different person now that she is all right."

This case, from its nature, result, and the period that has elapsed since the discontinuance of all treatment (four to five years), affords an opportunity for making a few observations preliminary to a more exhaustive communication on the subject of this distressing disease. Believing that ozæna is a disease of the mucous membrane, and that the atrophy or shrinkage which is characteristic of it is simply due to pressure of the hardened pus (crusts) upon that membrane, a condition which is somewhat analogous to that met with in the skin in certain forms of eczema, I have endeavoured by *curettement* to supplant the diseased membrane by new tissue, and the success I have met with in several instances, of which the above is an example, has warranted me in publishing this preliminary note. After curetting I have found

oily applications, such as a mixture of ichthyol and olive oil, soothing and beneficial. I may add that the patients upon whom this method of treatment has succeeded have been young, that is, from 10 to 25 or 30 years of age.

CASE OF INTRALARYNGEAL TUMOUR REMOVED BY THYROTOMY.¹

By JAMES MACKENZIE BOOTH, M.D.,

Surgeon Aberdeen Royal Infirmary, Lecturer on Diseases of the Ear and Larynx in the University of Aberdeen.

I HAVE thought the following case worthy of being communicated to the members of the Branch, not only on account of the infrequency of the affection in this part of Scotland, but also on account of its special features, and the operative treatment necessary for its relief.

The patient, Mrs. W., a married woman, aged 38 years, who, with the exception of a quinsy fifteen years previously, had always enjoyed robust health, first noticed a disagreeable sensation in her throat, causing her to make efforts to clear it, in July, 1892, at the time of her fifth confinement. A week later she began to suffer from hoarseness, which in three weeks resulted in complete loss of voice; for this an astringent pigment for the throat and a cough mixture were prescribed. During the latter part of 1892 and the beginning of 1893 the aphonia remained much the same, varying to a slight extent with the state of the weather, somewhat less marked when warm and dry, and worse during cold and wet.

In July, 1893, her medical attendant, Dr. Cheyne, advised her to apply to the ear and throat department of the Aberdeen General Dispensary. On laryngoscopic examination there, her symptoms were found to be due to the presence of a small tumour like a pea in the anterior commissure of the larynx, of the same colour as the laryngeal mucous membrane, which was redder than normal, and attached by a broad pedicle to the anterior fourth of the free border of the left vocal cord. Fig. 1 shows the condition observed in July,

Fig. 1.—July, 1893.

1893. Attempts to examine it with the probe and establish toleration of the laryngeal surface were repeatedly made without success, even with the aid of cocaine as pigment and spray. A pigment of zinc chloride of 30 grains to the ounce of glycerine was applied twice weekly to the larynx, and the patient enjoined to use steam inhalations of pine oil twice or thrice daily. Under this treatment the congestion diminished, and the subjective symptoms were benefited, the discomfort being less and the voice, though still hoarse, returning to some extent, but no apparent diminution was observed in the growth.

Towards the commencement of the cold weather, however, her symptoms got worse; she began to suffer from attacks of dyspnoea, and she was admitted to the Royal Infirmary on

Fig. 2.—October, 1893.

¹ Read at the December (1894) meeting of the Aberdeen, Belf, and Kincardine Branch.

October 20th, 1893. The tumour was found to have distinctly increased in size, and presented the appearance seen in Fig. 2. Again attempts were made to diminish the irritability of the larynx by means of cocaine preparations and the use of the probe unavailing. On this occasion, after a stay of a few days in hospital, it was determined that, as the patient was again pregnant, as endolaryngeal removal was impracticable, and as the dyspnoea, though often present, had not been such as to endanger life, she should be kept under observation and local medication persisted in. Pigments of chloride of zinc were applied at intervals of a few days during the winter, and the symptoms were again partially relieved. A marked change, however, was noted in the position of the growth, which for a time rendered the patient's condition much more comfortable. The tumour became more dependent and lay more below the rima glottidis than before, so that the attacks of dyspnoea were less frequent and troublesome.

In August, 1894, the patient was safely delivered of a daughter at full time, and made a good recovery. During the ensuing autumn the attacks of dyspnoea varied in frequency and severity, while the aphonia and sensation as of a foreign body remained constant. Towards the end of October the dyspnoea began to be constant, and the spasmodic attacks more readily induced, more frequent, more alarming, so much so that any extra exertion, or a particle of food, or drop of liquid swallowed the wrong way, caused a paroxysm threatening suffocation. As her condition grew steadily worse, she again applied for relief, and was admitted to the hospital on November 30th, 1894.

Her condition on admission was found to be much worse than when last seen. She had a markedly livid appearance and anxious expression, and her respiration was constantly stridulous. Sleep was exceedingly fitful and possible only when the patient lay on her left side. If she lay on her right side or on her back she was immediately attacked by a fit of breathlessness accompanied by a short barking cough.

On laryngoscopic examination the growth was seen to have increased much in size, so that it well nigh filled the whole subglottic area, leaving only a little space at the posterior commissure between it and the posterior wall of the larynx. It had also sunk somewhat, and appeared darker in colour than formerly. Fig. 3 is a sketch of its appearance on

Fig. 3.—December, 1894.

December 1st. Repeated attempts again failed to diminish the sensibility of the fauces and glottis. Seeing also that the larynx was of small capacity, the site of the tumour deep (that is, below the vocal cords), and its attachment chiefly in the anterior commissure, endolaryngeal treatment was plainly inadmissible. As the dyspnoea had become urgent, an extralaryngeal operation was determined on as the only means of giving relief.

On December 6th the patient having been anaesthetised as deeply as was deemed safe by Dr. Edmond, a skin incision an inch and a-half long was made in the median line of the neck over the thyroid cartilage. The cartilage having been sufficiently bared, a vertical incision was made through it extending from, but not dividing, the thyroid notch to the upper border of the cricoid cartilage. A sharp hook was applied to either side of the divided cartilage and gentle traction made, but there was still insufficient space to allow of the tumour being seized. A second incision was then made in the thyroid cartilage on the right side, that opposite to the attachment of the tumour, at right angles to the first, as in Fig. 4. A three-bladed dilator was introduced, and, on dilatation being made, the tumour was seen to be partially protruded at each expiration. It was then readily seized

and removed by means of cutting forceps, whereupon the breathing was at once perceived to be easier. The cartilage fell into place so accurately and evinced so little disposition to gape, that no suture was applied to it. The skin incision

Fig. 4.—Dotted line shows incision in thyroid cartilage.

was then closed with continuous catgut suture, and covered with a Lister's double cyanide gauze dressing. From the date of the operation the dyspnoea was completely relieved, and the patient made an uninterrupted recovery.

When the dressing was removed on the fifth day, the wound was found to have healed by first intention, and on laryngoscopic examination no trace of the growth beyond some reddening of the mucous membrane in the anterior part of the larynx could be seen. An astringent spray containing sulphate of zinc was ordered to be used several times daily for the treatment of the remaining laryngeal congestion. On the seventh day after operation, she could by an effort produce her natural voice, which she said she had not heard for two and a-half years previously. She was discharged from hospital on December 26th, quite free from the dyspnoea and laryngeal discomfort, but still somewhat hoarse, and with an occasional cough. On February 5th, 1895, the patient came up to hospital for examination, when she had recovered her natural voice, and only a faint redness of the left vocal cord showed where the tumour had been.

REMARKS.—In the record of the foregoing case, several points of interest may be noted. The occurrence of an attack of dyspnoea in certain positions of the head was latterly very striking. This happened if she lay on her back or on her right side, while if she were on her left side on her face or in the erect position, a comparative degree of comfort was attained. The situation and attachment of the growth readily supplied an explanation of these attacks, as in the dorsal and right lateral positions it would fall against and tend to block the rima glottidis, while in the prone, left lateral, and erect positions it would be drawn away from it. The symptom known as "expiratory dyspnoea" was not noticed, though in the later stage both inspiration and expiration were attended by stridor. The transverse cut in the thyroid cartilage and the use of the three-bladed dilator rendered the extraction much easier; and I believe that in all cases where thyrotomy is required for the removal of a growth with unilateral attachment, usually in a larynx of small size, a supplementary transverse cut is preferable to extension of the vertical incision, both for facilitating the operation, and the likelihood of restoration of the voice. Regarding the indications for extralaryngeal interference, it is rather difficult to lay down hard-and-fast rules, and, while it is generally conceded that danger to life is the sole indication for such interference, I question whether in some instances the discomfort and loss of voice do not themselves constitute a sufficient reason. The risk, though real, is slight, and I think that in previously healthy people, where the symptoms cause much distress, the question of extralaryngeal interference may still be entertained though life be not threatened by dyspnoea. In this case I am inclined to believe that an earlier operation might have been undertaken with advantage. The performance of a preliminary tracheotomy is in such cases unnecessary and generally unjustifiable as introducing extra risks of bronchitis, pneumonia, etc., which are not compensated for by increased safety or ease of operation, while, should necessity for it arise, tracheotomy can be carried out equally well when it does. Sections of the growth, kindly made by Dr. George Dean, show it to be a fibrous polypus, mainly composed of interlacing bundles of white fibres covered by several layers of epi-

thelium, a variety that does not usually tend to recur. The recovery of the normal voice is the exception rather than the rule after thyrotomy, from the risk of alteration of the relative position of the cords, and we may consider the patient fortunate in having recovered it after thirty months' disuse.

THE DEMONSTRATION OF MALARIAL ORGANISMS.

By C. DANIELS, M.B.CANTAB.,
British Guiana Medical Service.

HAVING seen something of the difficulties of applying the detection of the plasmodium malarie to practical diagnostic purposes, I should like to enter a plea for the examination of the blood for these bodies being made by staining them as more reliable than by examining the fresh blood, and more generally applicable. The difficulty is not with most men to find them, but to avoid mistaking for them the vacuolated corpuscles, common in a large class here, namely, the anemics. To avoid this Jaksch advises smearing the under surface of the slide with a solution of methylene blue, but this does not seem to give much help, and the general similarity of the two can be easily seen by comparing Jaksch plates of vacuolated corpuscles with some of Dr. Manson's diagrams.

If the intracorporeal bodies contain pigment there is, of course, no difficulty in distinguishing them, but unfortunately the commonest forms here contain either none or very finely divided pigment. Amoeboid movements would of course be a diagnostic point, but many men after examining a slide for half an hour or more (as recommended by Dr. Manson) with a $\frac{1}{4}$ th are very apt to make mistakes, particularly when dealing with bodies one-fourth to one-fifth the size of a red corpuscle, which is the commonest size here. As far as their occurrence in this Colony is concerned I have seen and demonstrated most of the forms in Dr. Manson's chart except B 10, 11, 12, C 12, D 11, 12, G 5, J 12, K 1, 2, 3, 4, 6, 11, 12, L 2, M 1, 9, 12, O 3, 6, P 6, 7, 11, Q 3, both in fresh blood and stained, and they are easier to find and more absolutely conclusive when seen stained.

Staining has the following advantages:

1. The bodies can be found with a $\frac{1}{4}$ th objective and recognised with ease and certainty with a $\frac{1}{8}$ th—no small advantage when the rapid deterioration of high objectives in moist tropical climates is considered.
2. Though extreme cleanliness is required, the absolute freedom from grease necessary to obtain the thin films required in fresh blood is not requisite. Cover glasses here become opaque in a very short time unless kept in some oil, from which it takes some time to absolutely free them.
3. The staining and examination can be done at one's own convenience. To examine fresh blood interferes with ordinary routine in a practice involving much travelling.
4. There are no other bodies in the blood, and no products or results of corpuscular degeneration with which they may be confused.

Hence we avoid what I believe to be common, mistaking anemic patients with vacuolated corpuscles for cases of malaria. Such cases are liable to pyrexia, either transient or irregular and intermittent, which does not yield to quinine, and in fatal cases shows no evidence of recent malaria.

Without adopting this method I believe we shall be unable to get sufficiently extensive reliable statistics to distinguish properly the non-malarial tropical pyrexias from true malarial fever.

The method of staining which I find gives the best results is that of staining with eosine and methylene blue separately, but I fully admit that I have often failed to get well-stained specimens.

If as detailed accounts of the best methods of staining these bodies as have been given for the examination of the fresh blood were published they would be largely used, and furnish much more reliable means of diagnosis for the mass of practitioners in our tropical colonies than the examination of fresh blood does.

NOTES ON AN OUTBREAK WHICH POSSESSED CHARACTERISTICS OF BOTH SCARLET FEVER AND DIPHTHERIA.

By RICHARD RICHMOND, M.D. EDIN.,
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AFTER reading the communication by Dr. Robert Lee on "Some Cases Resembling Scarlatina," in the BRITISH MEDICAL JOURNAL of February 16th, it struck me that the cases he referred to had a curious likeness to some which occurred in my practice about a year ago. In reply to a letter from me he wrote saying that he thought them like those he had described. Given as shortly as possible the facts were as follows: On February 8th, 1894, whilst I was attending the wife of a labourer who had been recently confined, I was asked to see her child, aged 9, who had been, as she considered, bilious; in reality the child presented no other symptoms beyond some slight fever and redness about the fauces and tonsils. Forty-eight hours after examining this child I commenced to be ill myself, and soon developed a sharp attack of follicular tonsillitis. On February 13th I received a note from my friend, Mr. R. C. Lyle, who had seen my patients for me on the previous day, saying that the child was suffering from scarlet fever. It seemed very probable therefore that I had contracted my "throat" from this case, and in the light of future events this seemed almost certain.

A sister of the child next went down with scarlet fever, then the child of a neighbour, and then two cousins, all of whom had been visiting the house. Following these closely were what my *locum tenens*, Dr. W. R. McKinnell, considered to be diphtheria, two in the neighbour's house in which there was already scarlet fever, and one in the house in which the cousins were suffering. Two of these were adults, male and female, aged 50 and 65, and the third was a boy aged 10. The male adult was the last case. I saw him about the second or third day of his illness, and on each tonsil there was a patch of dirty white membrane, not much raised from the surface; he complained of great weakness. The first three cases of scarlet fever were of moderate severity, but had marked throat symptoms. The next two, however, assumed a most malignant type, and ended fatally. These two children (girl and boy) were aged 9 and 16 respectively.

I was unable at the time to discover anything to account for the origin of these cases, but shortly afterwards I had a neighbour's child brought to me whose urine contained a large quantity of albumen, and who showed signs of having recently desquamated. This child had been attending school in a neighbouring parish in which there had been a good many cases of slight character, and she had probably contracted infection there. But how came the disease to assume so malignant a type in being carried from one parish to another? The cottages were in a perfectly sanitary condition, and there was nothing to account for the diphtheria, so called. Concurrently with the last cases of this outbreak there occurred in a hamlet three miles away another case of scarlet fever which had no direct connection with them, nor was it possible to discover from whence the infection had come. This child infected another, and both presented a copious rash and sore throat—in fact, they seemed to be typical examples of scarlet fever. I have used the expression "direct connection" because there was an indirect relationship between these and the other cases, which was curious if nothing else.

For several weeks previous to the occurrence of the first case of the outbreak I had been attending a confinement case in which the discharges had become septic, and, in spite of stringent antiseptic measures, the mother of the children first attacked (whom I have mentioned as being confined on January 30th) became affected to a slighter extent in the same way. In a third instance the same thing occurred, and this woman lived in the hamlet three miles away, in which the last cases of the scarlet fever occurred; the mother of the child first attacked nursed the lying-in woman, and the child used to visit the house. No one of the three affected women was ever dangerously ill, the temperature never rising beyond